Washington Association of Designated Mental Health Professionals

Safety Summits Report

To Washington State Mental Health Division

November 2006

Summary of Information Collected from Stakeholders Relating to Safety of Outpatient Mental Health Workers

Acknowledgements

The sponsors of the Washington State Safety Summits would like to express their appreciation and gratitude to the planning committee members who provided input and gave their time to plan, gather information, and arrange presenters for the Summits. Committee members include:

Ann Christian	Washington Community Mental Health Council
Ann Glynn	North Central Regional Support Network
Anthony O'Leary	Mental Health Division
Bea Dixon	Kitsap Mental Health Services
Darlene Vernon	Mental Health Division
David Kludt	Mental Health Division
Drew McDaniel	Lower Columbia Behavioral Health
Ian Harrel	Washington Association of Designated Mental Health Professionals
Jan Dobbs	Spokane Mental Health
Jo Moore	King County Crisis & Commitment Services
Louie Thadei	Mental Health Division
Marie Manlangit	Service Employees International Union 1199 NW
Tami Green	Washington House of Representatives

The sponsors would like to acknowledge the following Summit presenters who provided beneficial information to participants on Legislative Topics, Facility Design, Law Enforcement Safety in Outreaches, Access to Information, Training, Clinical Judgment, and Collaboration:

Ann Glynn	North Central Regional Support Network
Bea Dixon	Kitsap Mental Health Services
Darlene Vernon	Mental Health Division
Drew McDaniel	Lower Columbia Behavioral Health
Jan Dobbs	Spokane Mental Health
Jo Moore	King County Crisis & Commitment Services
Joe Fountain	Seattle Police Department
Keith Cummings	Spokane Police Department
Leslie Gamble	Ergonomic Specialist
Tami Green	Washington House of Representatives
Tim Davis	Compass Mental Health

Finally, the sponsors would like to thank the individuals who completed the Safety Summit Questionnaires providing valuable input relating to safety issues in doing their work.

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Executive Summary

Purpose

The Mental Health Division of the Department of Social and Health Services sponsored two Safety Summits in September 2006 with the intent to convene key stakeholders throughout the state in order to provide education and share ideas on issues related to the safety of outpatient community mental health workers. The decision was made to take a statewide look at safety concerns and practices in the wake of a number of recent incidents involving assailants with mental illnesses, including the death of a Kitsap County mental health professional in 2005. The Mental Health Division contracted with the Washington Association of Designated Mental Health Professionals (WADMHP) to construct and present the two full day Summits. Funding for the events was provided through a federal block grant. This report is a product of the WADMHP and reflects information presented at and gathered from the two Summits as well as data collected through the Safety Summit Questionnaires.

Process

The Mental Health Division (MHD) and the Washington Association of Designated Mental Health Professionals (WADMHP) organized a planning committee for the Summits in the summer of 2006. The planning committee consisted of representatives from community mental health providers and crisis teams, Regional Support Networks, the WADMHP, the Washington Community Mental Health Council, the MHD, and the Service Employees International Union. The committee met to discuss the content and development of the Safety Summits and to create a questionnaire for participants to complete. Four general topics for the Summits were decided upon: Collaboration with Other Stakeholders, Training, Clinical Judgment, and Access to Information. A brochure advertising the Summits was distributed via community mental health agencies, the Regional Support Networks, the WADMHP, and the Washington Community Mental Health Council. A full day Summit was held on the west side of the state at Western State Hospital and on the east side of the state in Pasco. Individuals were asked to complete the Safety Summit Questionnaire at the Summits or via email if they were unable to attend.

Information was solicited from community mental health providers regarding policies and procedures and best practices relating to safety. A summary of this information is provided as an appendix to this report.

The Safety Summit contract between the MHD and the WADMHP contained three payment points. The first payment point was met by the WADMHP participating fully in Summit planning activities including identifying and contracting with speakers, advertising the Summits, coordinating registration, and documenting attendees. This first payment point also included creation of the Safety Summit Questionnaire. Payment Point Two was satisfied with the completion of the first of the two Safety Summits and the distribution of the questionnaires. The third payment point was met when the second Safety Summit was completed and questionnaires distributed. Both agendas for the Summits and the questionnaire are attached at the end of this report.

Safety Summits

The first Safety Summit took place on Monday, September 18, 2006 from 8:30 am to 4:30 pm at Western State Hospital. There were fifty-four (54) participants. The second Safety Summit was held in Pasco on Wednesday, September 20, 2006 from 8:30 am to 4:30 pm and involved twenty-two (22) participants. The seventy-six (76) Summit attendees included representatives from the following organizations:

Caregivers/Advocates
Community Mental Health Providers
Consultants/Private Practice Practitioners
Division of Developmental Disabilities (DDD) Agencies/Facilities
Department of Labor & Industries
Mental Health Division
Police Departments
Psychiatric Hospitals
Residential Facilities
Service Employees International Union 1199 NW
Tribal Mental Health
Washington Association of Designated Mental Health Professionals
Washington Community Mental Health Council

A total of eleven speakers presented information relating to safety in outreaches and facility design as well as information on the four Safety Summit topics (Collaboration with Other Stakeholders, Training, Clinical Judgment, and Access to Information).

Washington State Representative Tami Green discussed the Marty Bill that she introduced earlier this year and advocated for mental health workers doing outreaches in pairs.

Leslie Gamble, an ergonomic specialist with Interior Health of British Columbia, Canada, provided information on facility design to decrease the impact of violence for mental health workers.

Joe Fountain, an officer and safety instructor with the Seattle Police Department, and Keith Cummings, an officer with Spokane Police Department presented information on prevention and awareness, threat assessments, safe contact practices, and collaboration with police.

Darlene Vernon of the Mental Health Division and a member of the Safety Summit workgroup talked about available systems and needs relating to accessing mental health client information.

Drew McDaniel, Director of Emergency Services at Lower Columbia Behavioral Health in Longview and Ann Glynn of North Central Regional Support Network, both members of the Safety Summit workgroup, provided information on models for staff safety training.

Jo Moore, Director of King County Crisis and Commitment Services and Bea Dixon of Kitsap Mental Health Services, both Safety Summit workgroup members, presented key points in exercising clinical judgment.

Tim Davis of Compass Health and Safety Summit workgroup member Jan Dobbs of Spokane Mental Health discussed steps involved in systems collaboration.

David Kludt of the Mental Health Division and Ian Harrel of the Washington Association of Designated Mental Health Professionals facilitated discussion around the topics presented and proposed questions to the group.

Comments from the participants included the following, which are direct quotes from attendees:

Outreach Worker Skills

- Possibly implement different type of screening when interviewing for DMHPs as demands are different, education levels are different. Work with H. R. Directors to determine what skills are needed for outreach workers.
- Crisis workers should have several years experience with chronic mental illness before being considered for crisis job.
- Learn from those who stay in the field – what skills are needed in doing crisis work.
- Pay is a factor in why some stay in the field – pay for DMHPs varies across the state.
- Length of employment doesn't necessarily make them good at the job.

Outreaches in Client Homes

- Outreaches should be done in client homes but need police support
- Outreaches in homes give you an accurate picture of client's environment that you don't get in an emergency room.

Outreaches in Pairs

- Mandating 2 people is not something I support. We provide all in-home care and have had no incidents due to screening, experienced staff, management support, providing 2 people when needed, and not going at all if you are at risk.
- One size doesn't fit all – I don't support outreach workers always working in pairs.
- May need a set of universal precautions like they use in medical care – standards to always follow.
- If the Marty Smith Bill passes, how will it be funded? Can't send 2 people out without additional funding.
- We are getting double messages – increase your productivity and go out in pairs. We can't do both.
- I have seen more assaults in facilities where there are lots of people than in homes. Going in pairs doesn't guarantee safety.

ITA Investigations in Secure Setting versus Client Home

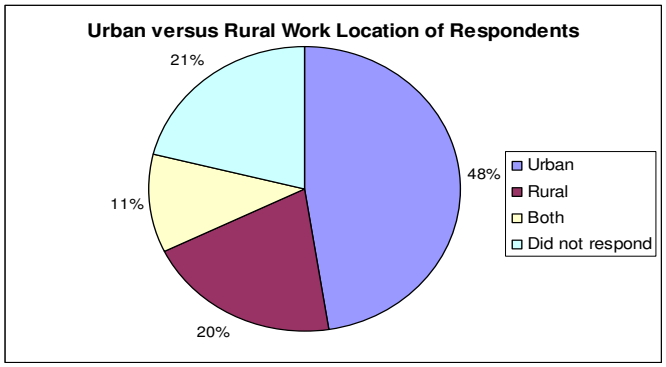
- We do all ITA investigations in emergency rooms. We need to have drug screen and medical clearance before admitting anyway.
- There are a higher number of detentions from emergency rooms versus the home because clients are much more agitated in the ER so you don't get an accurate picture.
- When my son was very ill, it was most helpful to have DMHP and police come to the home. Should work in teams and have police liaison.

Safety Summit Questionnaire

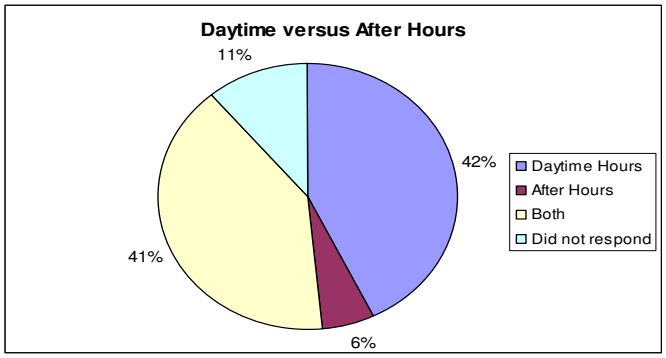
The Safety Summit Questionnaire was comprised of some demographic information and twenty-three (23) questions relating to assaults, safety practices, and training. The Questionnaire allowed respondents to include their name and title or to remain anonymous if desired. The Questionnaire was distributed and collected at both Safety Summits and was also available by email. One hundred forty three (143) questionnaires were completed. Of those that identified themselves, most respondents were case managers/counselors, DMHPs/crisis interventionists, and management in that order. Other respondents included administrative support staff, inpatient mental health staff, medical staff, Division of Developmental Disability providers, private practice mental health practitioners, client/family advocates, and peer counselors.

Respondent Demographic Information

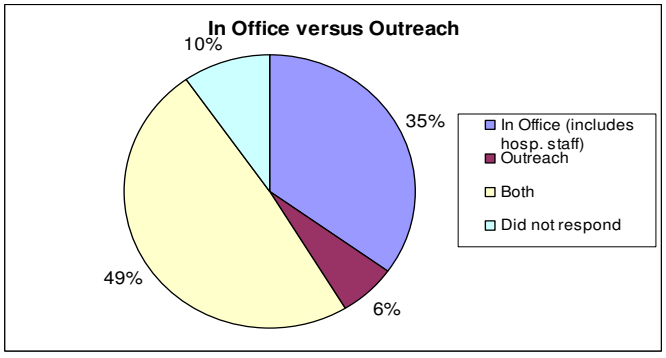
Forty-eight percent (48%) of respondents reported working in an urban environment.



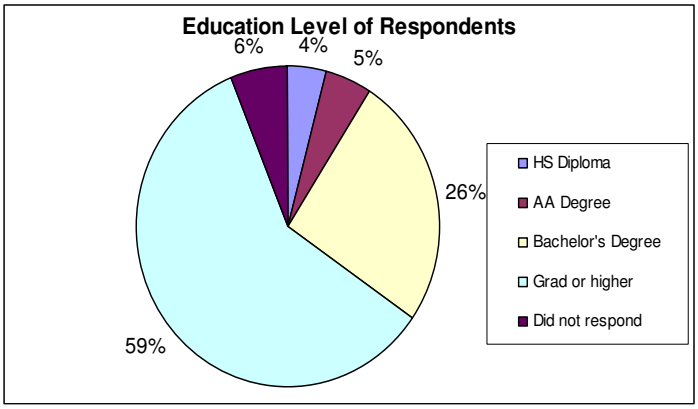
Forty-two percent (42%) identified that they worked daytime hours and forty-one percent (41%) indicated that they worked both daytime and after hours.

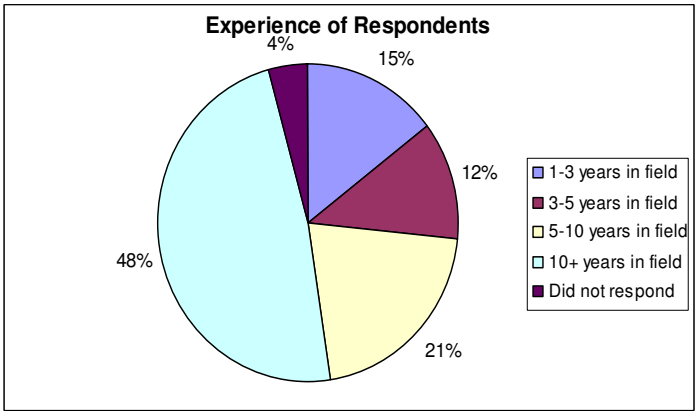


Almost half of the participants (49%) reported that they worked both in an office and doing outreach.



Overall, most respondents have a graduate degree or higher (59%) and have been working in the mental health field for more than 10 years (48%).



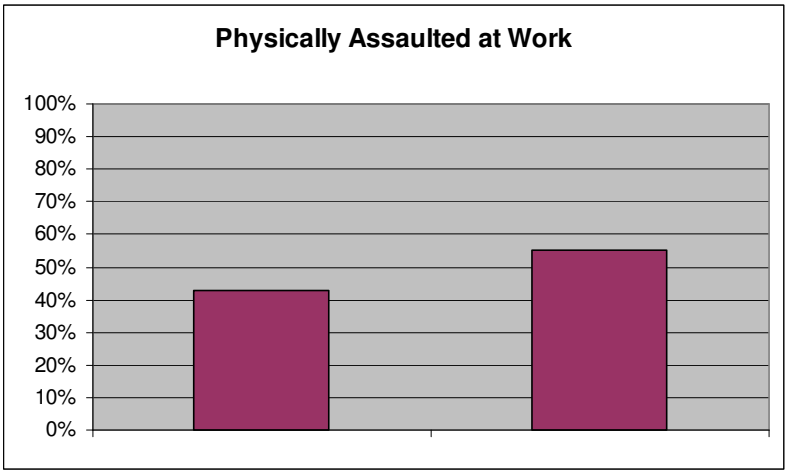


Safety Summit Questionnaire Responses

The first five questions inquire about physical assaults at work and ask details about the assaults including whether medical attention was required, the location of the assault, whether the respondent was alone at the time of the assault and whether they thought their agency took appropriate action in responding to the incident.

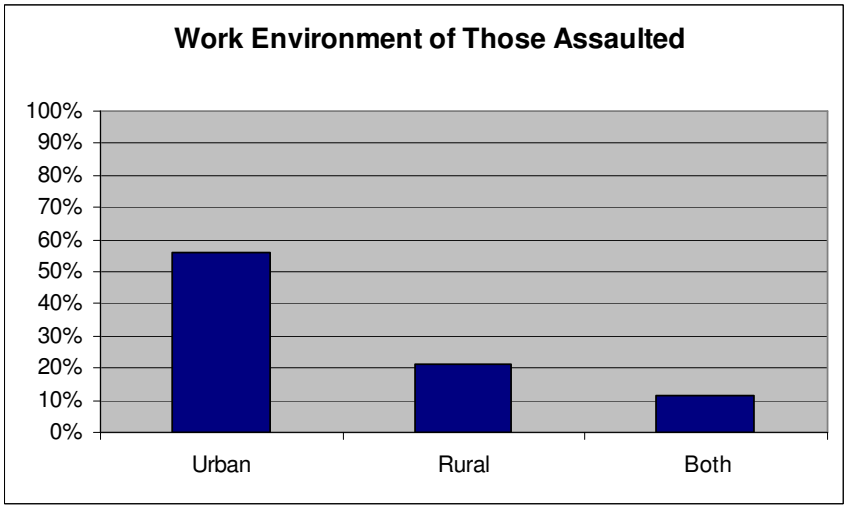
Forty-three percent (43%) of respondents indicated that they have been assaulted at work while most (55%) reported they have not.

Figure 1



Most of these individuals work in an urban environment. Twenty one percent (21%) work in a rural location and eleven percent (11%) report that they work in both urban and rural environments.

Figure 2



Most assaults reported by participants (82%) did not require medical attention. Most of the assaults occurred in the agency (62%) and most participants (77%) reported that they were not alone when the assault occurred.

Required Medical Attention		Assault Location			Alone versus Not Alone	
Yes	No	Client's Home	Agency	Other	Alone	Not Alone
18%	82%	13%	62%	25%	23%	77%

In Figures 3 and 4, the assault locations and whether staff were alone or not are broken down by those who work in urban environments, rural environments, and those who report they work in both. For all categories, assaults that occurred in the agency are the most common. For rural environments, assaults in other locations were as common as agency assaults. The "Other" category includes places like hospital emergency rooms and jails. Individuals working in urban or rural locations were more often not alone when assaulted while those working in both rural and urban environments report they were alone more often.

Figure 3

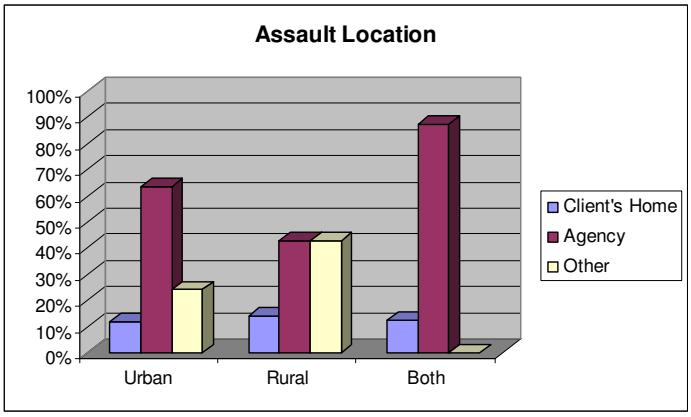
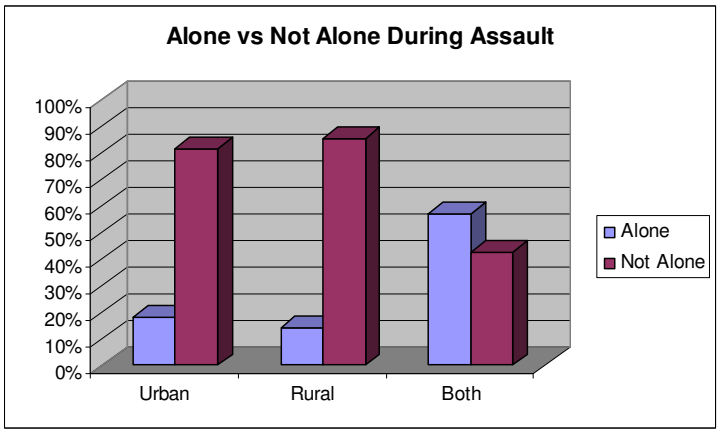
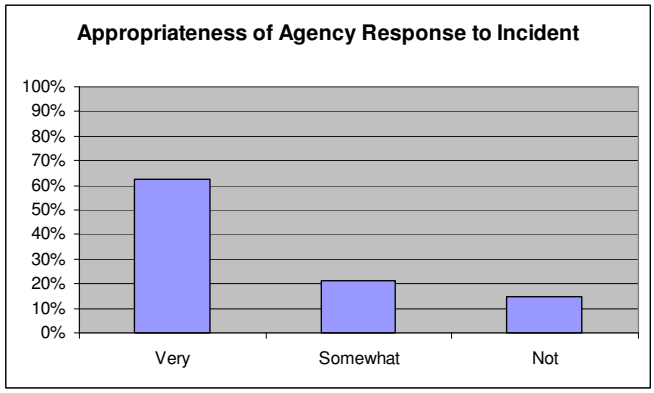


Figure 4



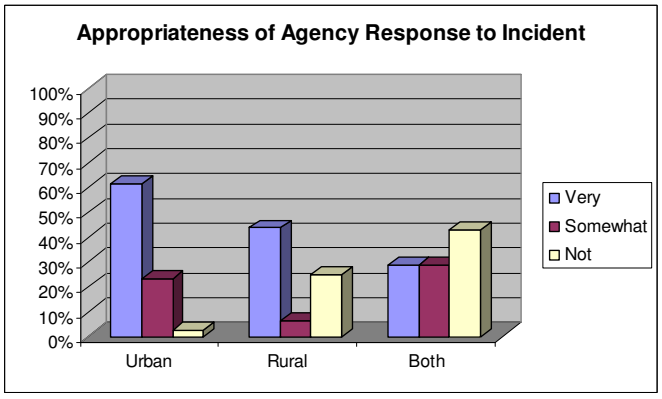
Most respondents (62%) believe that their agency responded very appropriately after the assault. Two percent (2%) did not respond to the question.

Figure 5



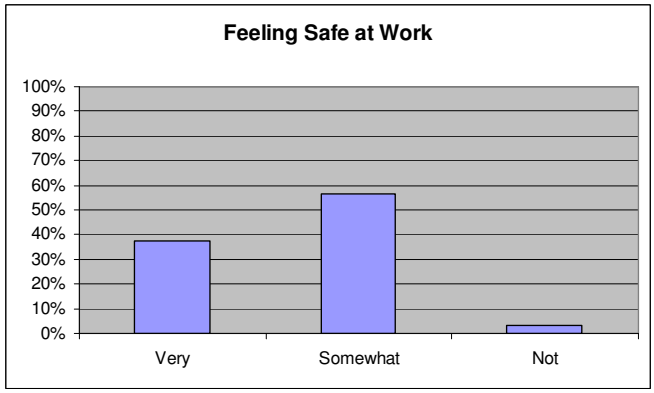
As shown in Figure 6, most respondents who work in urban environments and half of those working in rural environments believe that their agency responded very or somewhat appropriately after an assault. For those reporting they work in both environments, forty-three percent (43%) believe their agency did not respond appropriately.

Figure 6



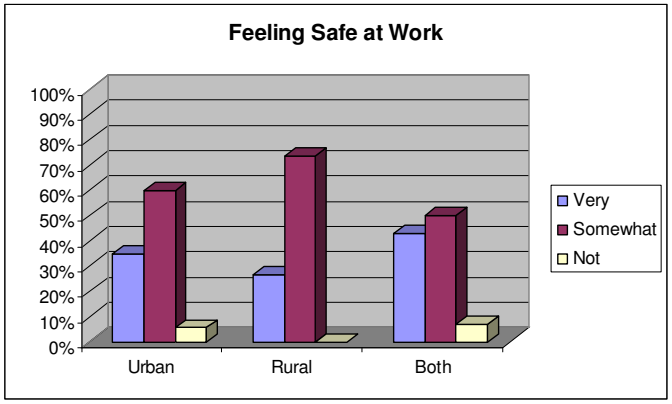
The next set of questions relate to feeling safe at work and to agency training and policies. Most participants feel very or somewhat safe in doing work identified as primary duties. Three percent (3%) report they do not feel safe.

Figure 7



In Figure 8, the responses to the question about feeling safe at work are broken down by work environment. Overall, across all environments, most respondents feel safe at work.

Figure 8



Most participants (91%) reported that their agency has policies relating to safety.

Figure 9

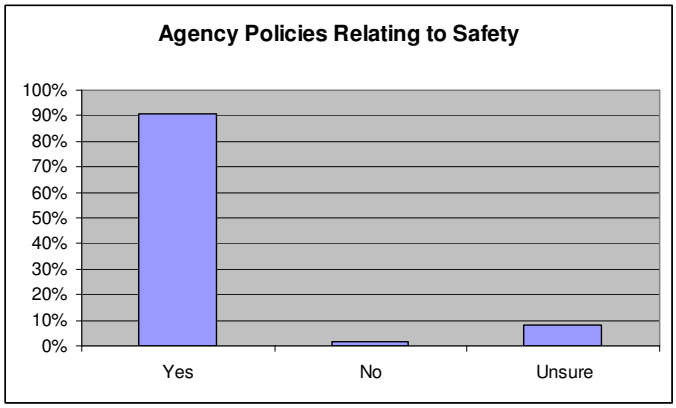
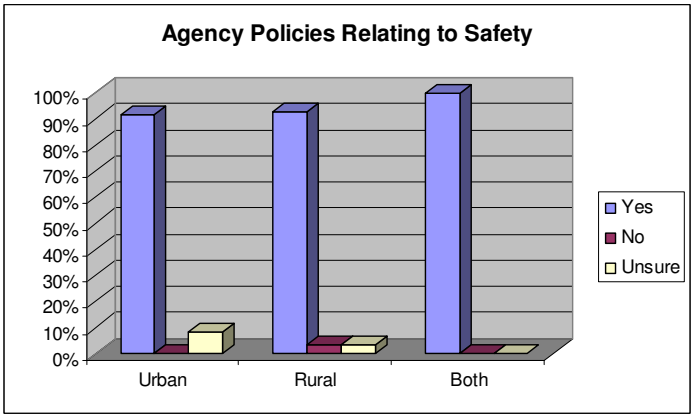


Figure 10



According to respondents, most of them (93%) have received some type of safety training at work (Figures 11 and 12). Overall, respondents reported that the training addressed their concerns (Figures 13 and 14).

Figure 11

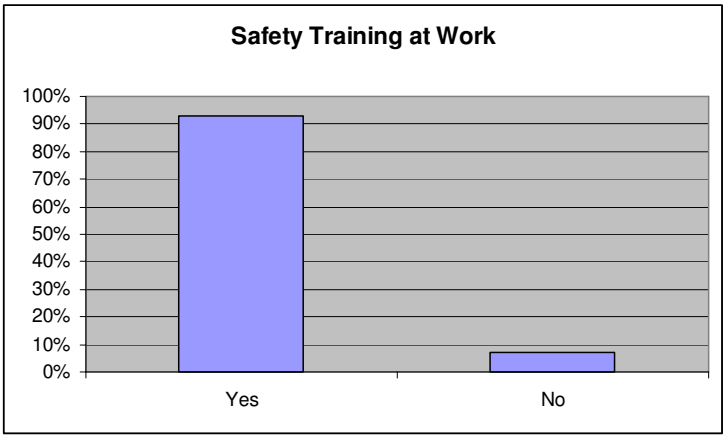


Figure 12

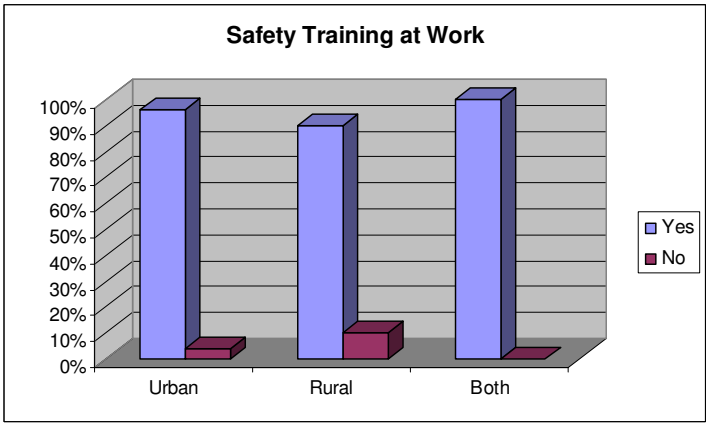


Figure 13

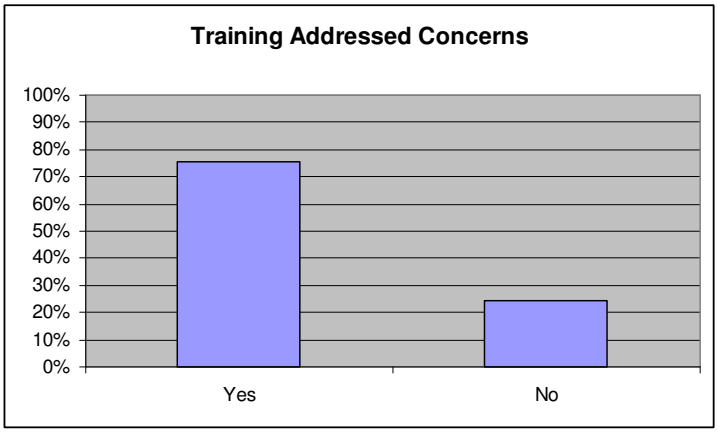
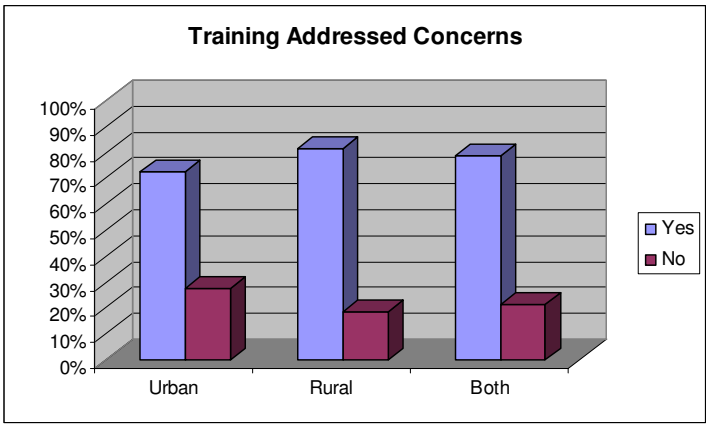


Figure 14



Most participants (60%) reported their agency has policies that allow for two employees to go on outreaches when needed. As depicted in Figure 16, this is true for those working in all three work environment categories.

Figure 15

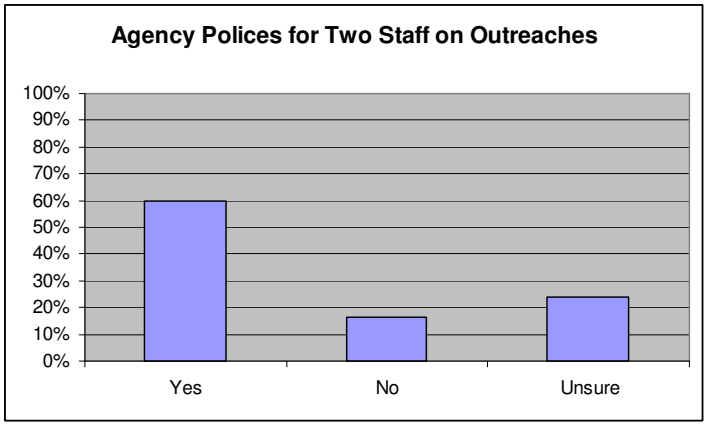
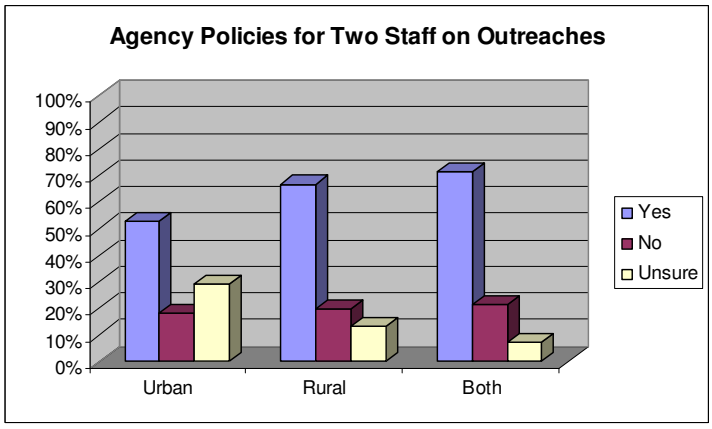


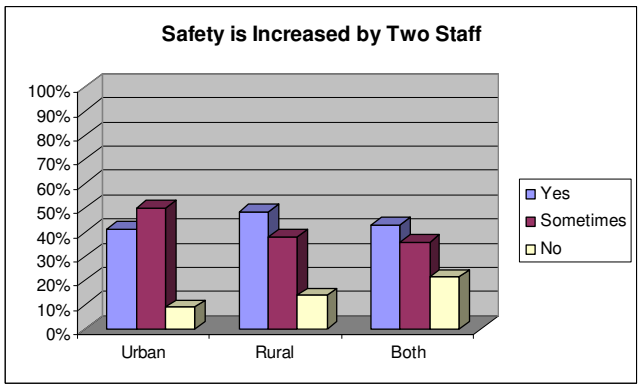
Figure 16



When asked if they believe that their personal safety would be increased by the presence of another agency staff when doing outreaches, forty-four percent (44%) said "yes," forty-five percent (45%) said "sometimes," and eleven percent (11%) said "no." Figure 18 shows the breakdown by working environment. For those working in rural and both urban and rural environments, most believe their safety is increased by the presence of another staff. Most of those working only in urban locations report that their safety is sometimes increased by the presence of another person.

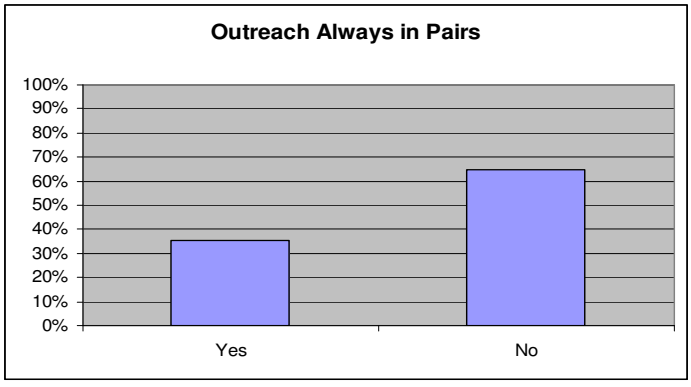
Figure 17

Figure 18



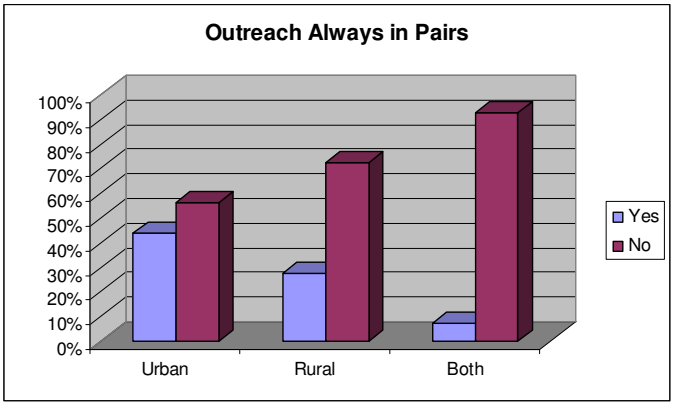
Most individuals completing the questionnaire (65%) do not believe that mental health staff doing community outreach should always work in pairs.

Figure 19



When looking at the responses by work environment, more than half in each category do not believe that outreach workers should always work in pairs as shown in Figure 20.

Figure 20



Participants were asked if they are able to request a partner for outreach when they have safety concerns. As shown in Figure 21, eighty-nine percent (89%) reported that they are able to request a partner. Figure 22 shows that most respondents across work environments are able to request a partner for outreaches when they have concerns about their safety.

Figure 21

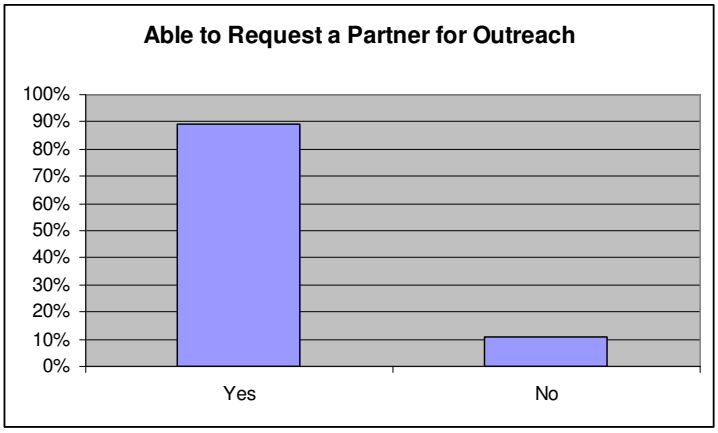
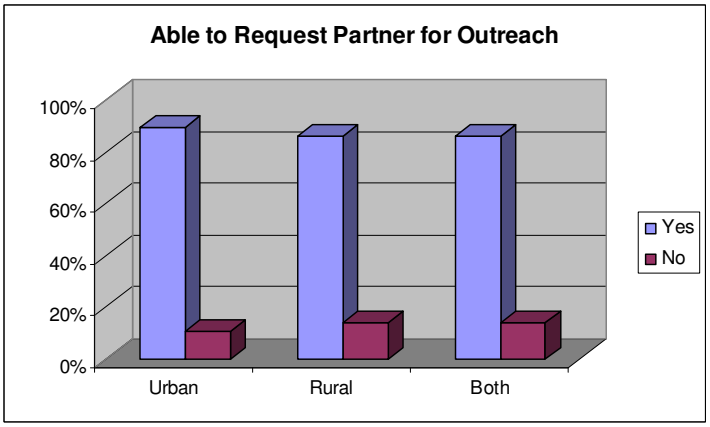


Figure 22



A separate item on the questionnaire inquired whether respondents believe that crisis outreach should always be done in pairs. Figure 23 shows that fifty-six percent (56%) of respondents believe that this work should be done in pairs. As shown in Figure 24, most of those who work exclusively in an urban or rural location believe that crisis outreach workers should work in pairs while most of those working in both environments do not agree with this.

Figure 23

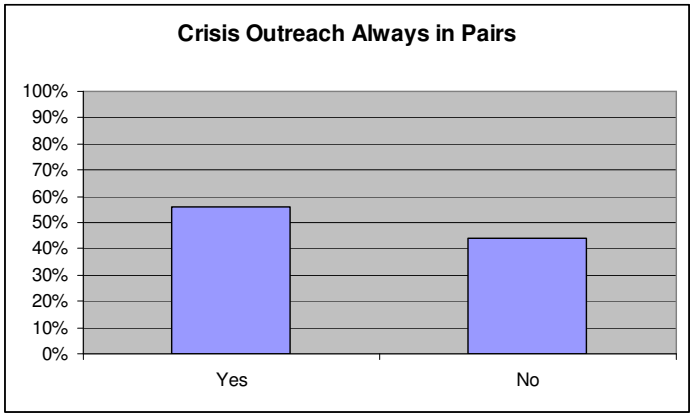
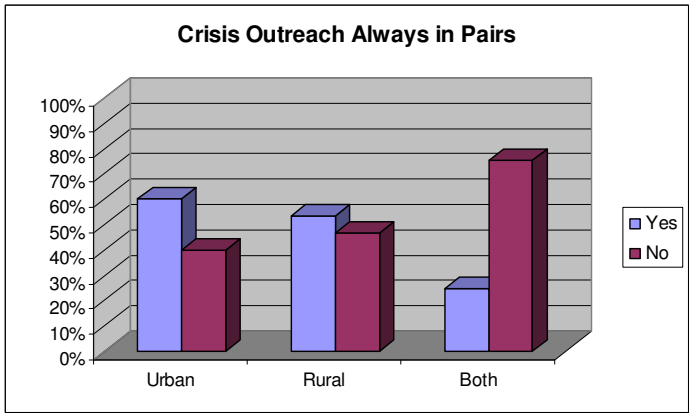


Figure 24



Eighty-nine percent (89%) of participants reported they are able to request a partner for a crisis outreach when they have safety concerns as shown in Figure 25.

Figure 25

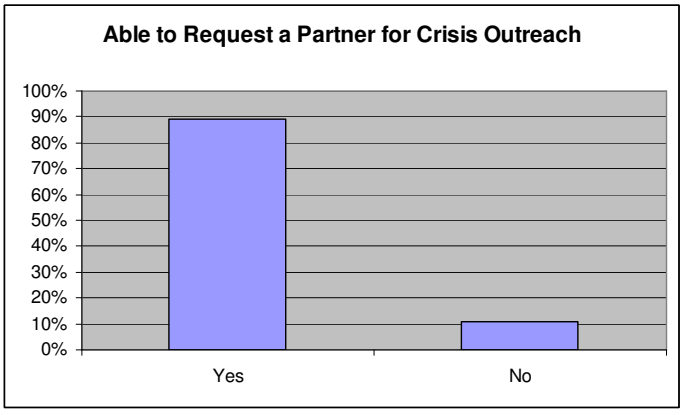
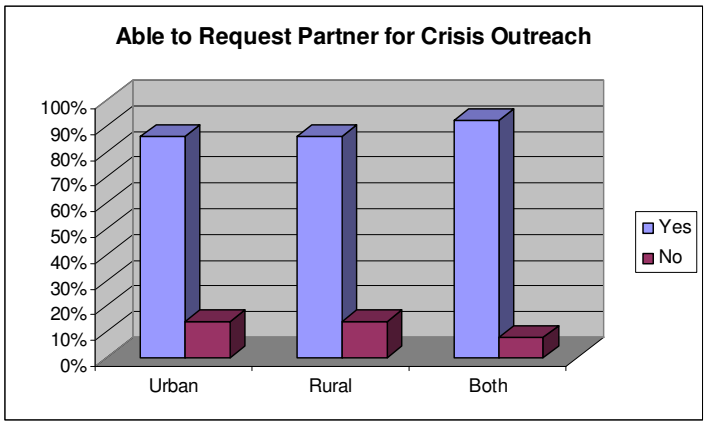


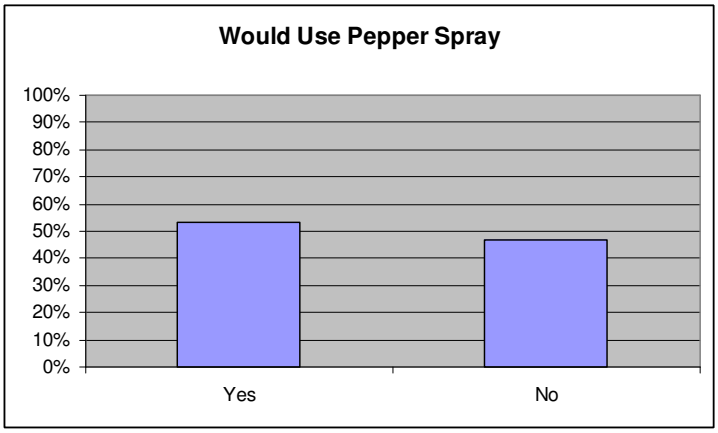
Figure 26 shows that most participants across work environments are able to request a partner for crisis outreach when they have concerns about safety.

Figure 26



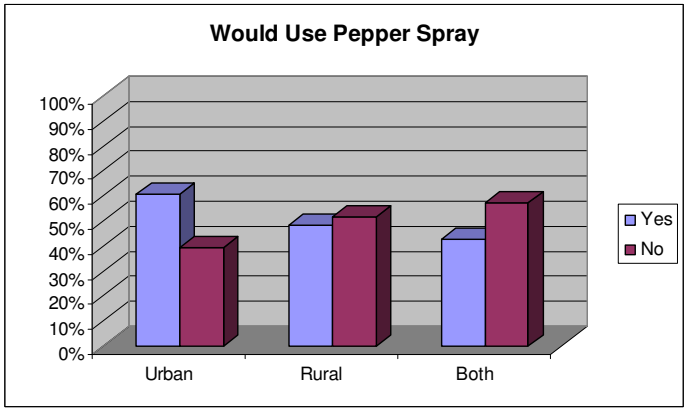
An item on the questionnaire asked respondents if they would choose to use pepper spray if their agency had a policy that allowed for it. As depicted in Figure 27, fifty-three percent (53%) would choose to use it while forty-seven percent (47%) would not.

Figure 27



More people in urban environments would choose to use pepper spray while more people in rural and both environments would choose not to use it as shown in Figure 28.

Figure 28



When asked if they would choose to wear protective clothing if their agency allowed it, most respondents (74%) reported they would not choose to wear it and twenty-six percent (26%) stated they would wear it. Most respondents across all working environments would choose not to wear protective clothing as shown in Figure 30. Some respondents suggested that outreach workers should not be asked to go into situations where they feel they have to wear protective clothing.

Figure 29

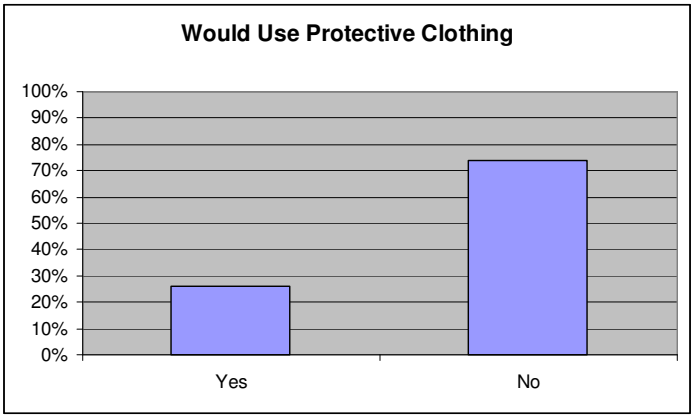
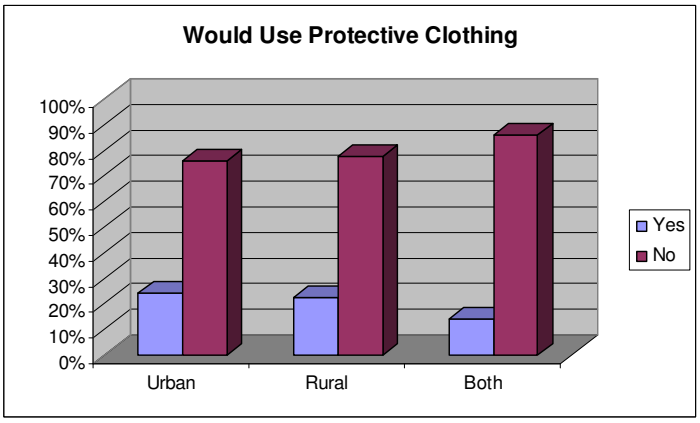


Figure 30



Most participants (90%) believe that law enforcement is helpful when contacted during the course of doing outreaches and this is true for all working environments as shown in Figure 32.

Figure 31

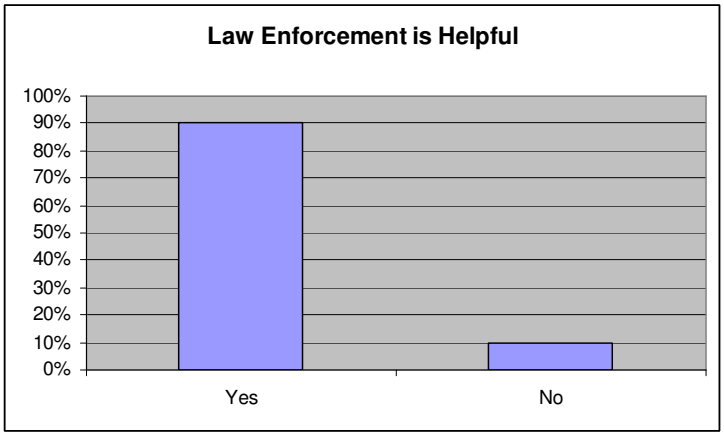
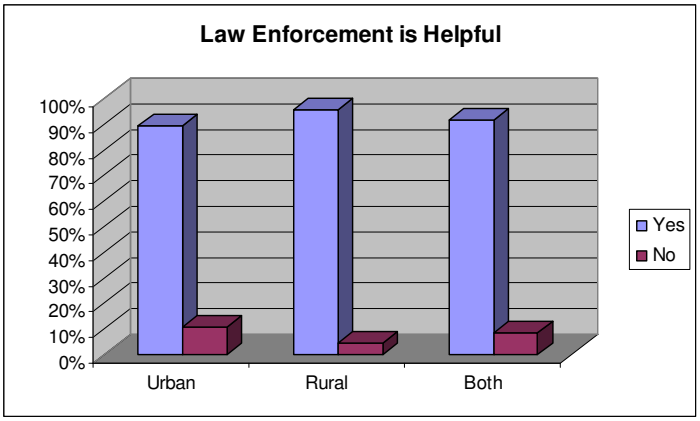


Figure 32



Nineteen percent (19%) of respondents reported that they always have access to necessary information relating to clients in order to make decisions about safety. Most (76%) stated that they sometimes have access to important information. Figure 34 displays the access to information responses by working environment. Most reported that they only sometimes have access to information.

Figure 33

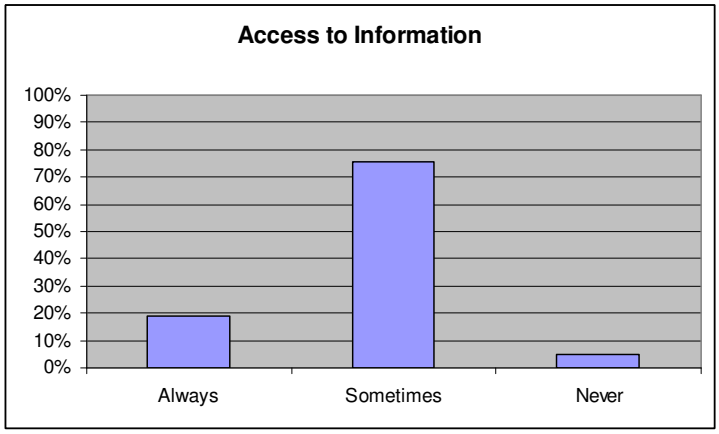
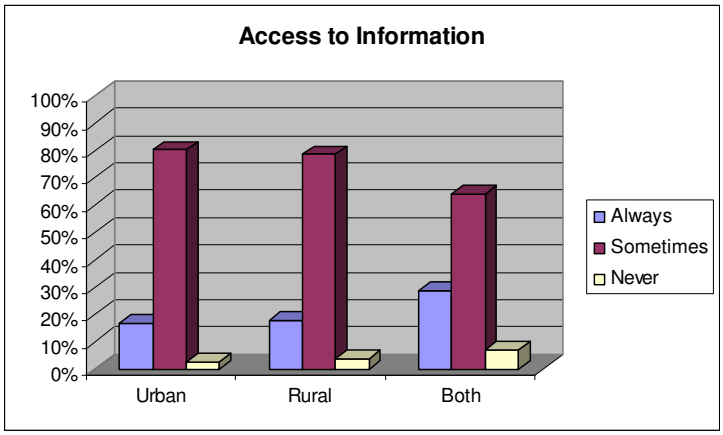


Figure 34



Participants were asked if they believe that the state should financially support and require community mental health providers to provide a standardized safety training curriculum or if individual agencies should establish their own training curriculum. Most (62%) reported that they believe there should be standardized statewide training. Figure 36 shows that most respondents working exclusively in urban or rural locations prefer a standardized statewide training while those who work in both environments prefer agencies to develop their own curriculum. Some participants (9%) indicated that they believed there should be both standardized statewide training and specific agency training based on agency needs.

Figure 35

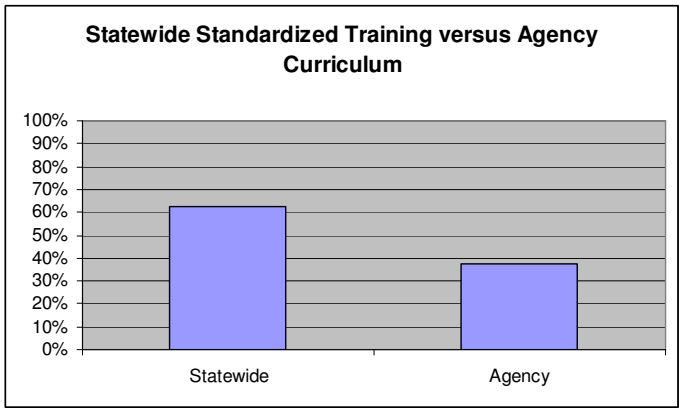
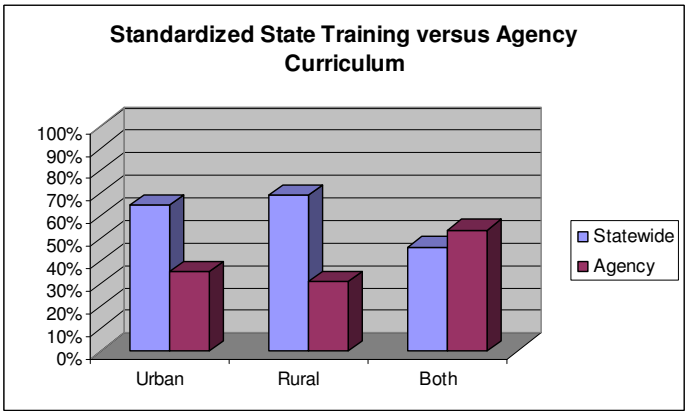


Figure 36



Safety Summit Questionnaire Respondent Comments

Training Needs

The Safety Summit Questionnaire asked participants what additional training would be most helpful to them. Most comments related to getting more frequent training, learning self-defense techniques, and getting to practice the training by participating in drills frequently. The other common training requests were de-escalation techniques and assessing the environment. Less common themes but still mentioned multiple times were more job-specific training instead of agency-wide and training on dealing with animal threats. Other desired training included instruction on working with individuals who are under the influence of substances and assessing homicidal ideation. A suggestion was made that law enforcement and mental health outreach workers train together. Some individuals believe more training is needed for community outreach workers on the limitations of Designated Mental Health Professionals and law enforcement.

Training Request	% of Respondents
More frequent safety training	23%
Self-defense techniques	22%
Practice – safety drills	17%
De-escalation techniques	12%
Assessing the environment	11%
Job-specific training	8%
Dealing with animal threats	3%

Feeling Safe

When asked what they need in order to feel the most safe in doing their job, the participants most commonly reported needs related to adequate training and access to important information.

Training needs identified were mentioned above. Other comments relating to training included more DMHP-specialized training similar to what law enforcement safety training, risk assessment, personal safety, and self-defense.

Information that respondents noted as necessary before intervening with a client included law enforcement arrests and convictions, findings of incompetence by reason of insanity, admissions to forensic units, forensic evaluations, client involvement in mental health services or alcohol and substance abuse services. It was mentioned that information obtained through the WATCH system is not adequate or complete.

Respondents stated that a more secure work environment and good safety equipment would help them feel safe. Controlled access to buildings, metal detectors, on-site security, regular facility safety inspections, duress alarms/panic buttons, and cell phones were items mentioned related to safer facilities and safety equipment.

Additionally, some indicated that working in pairs would help them feel safe in some situations. There were multiple comments relating to collaborating with law enforcement and other professionals. Other common themes included increased mental health funding for training and more staff, clear agency policies, increased staffing, good supervision and having access to supervisors, management support, more experienced staff, and the ability to use good judgment. Some participants indicated that they do feel safe in doing their job due to good training, established relationships with law enforcement, and doing crisis contacts in emergency rooms or jails only.

Needed to Feel Safe	% of Respondents
Comprehensive, frequent training	33%
Access to needed information	33%
Secure work environment	17%
Doing outreaches in pairs	17%
Collaborating with police when needed	14%
Safety equipment	14%
Increased funding for training and more staff	8%

Additional Comments Relating to Safety

Respondents were asked for any additional ideas they have relating to safety. Most comments in this section related to the need for more frequent standardized training, increased funding to mental health providers so that more staff can be hired in order to decrease caseloads and have a 2nd staff available for outreaches, and the pros and cons of two-person outreaches.

Comments in favor of two-person outreach included:

- If outreach workers see clients any place other than emergency rooms or jails where there are lots of people, they should be mandated to go in pairs so that they have assistance if needed.
- Two-person outreaches should be standard of practice, even for smaller agencies.
- Use two-person outreaches when needed.
- It should be a requirement that all DMHPs go in pairs on every outreach as they don't always know what they are walking in to.

Comments not in favor of two-person outreach included:

- Two-person outreaches would be hard to do on a regular basis because it would take staff away from scheduled appointments during the day and would cause sleep deprivation for staff who would go out at night and have to work the next day – use one person for crisis work and have them do it in a controlled environment.
- Currently, there isn't a way to bill for two providing one service in a fee for service environment.
- We are unable to get credit in terms of state productivity standards for contacts where two staff are providing one service.
- Always working in pairs is a waste of money and clinically unsound. This would dramatically stigmatize mentally ill people as universally dangerous. Most aren't dangerous.
- Concerned about a mandate without funding attached.
- Good policies, training, collaboration with law enforcement, and access to information are way more valuable than always sending two people. Sending two untrained people will just end up in two people getting hurt. One person that was killed in Washington State had police with him. There will always be a risk factor in doing this job.
- Allow us to use our good judgment in going to an outreach alone, going with a colleague or police, or not going.

Additionally, some respondents believe that outreach workers should be more experienced and should receive extensive training before going out alone. It was noted that mental health work is unpredictable by nature and there is no substitute for experience and good judgment.

Summary

General recommendations from the Safety Summits and the Safety Summit Questionnaires include provide more frequent training for mental health outreach workers. A standardized statewide training is preferred by most of the questionnaire respondents. Another recommendation is to ensure that important information is accessible to outreach workers before they see clients so that risks can be appropriately assessed. Outreach in pairs should not be mandated but should be an option when mental health workers determine there is a need for a second person due to safety concerns. Most individuals responding to the Questionnaire believe that crisis outreach specifically should be done in pairs. Work should be done to continue to collaborate with law enforcement in developing protocols for responding to requests for assistance in outreaches to mental health clients in crisis when safety is a concern. Community mental health providers should continue to develop their agency-specific policies and training pertaining to safety, including facility inspections and evaluation of safety equipment needs.

Washington Association of Designated Mental Health Professionals Statement

The Executive Committee of the Washington Association of Designated Mental Health Professionals would like to thank Washington State Mental Health Division for sponsoring this effort to improve safety for mental health outreach workers. We would like to offer the following recommendations to the state for consideration, as we believe that these measures will assist in increasing the safety of mental health outreach workers.

- Develop mandatory state-wide standardized training that addresses safety issues for all mental health outreach workers, including DMHPs
- Offer DMHP boot camps two times per year to ensure standardized training is provided to all new DMHPs
- Provide 24-hour DMHP access to information such as arrests and convictions, findings of incompetence by reason of insanity, admissions to forensic units, forensic evaluations, client involvement in mental health services or alcohol and substance abuse services. In addition, determine which of these can be made available to all mental health workers.
- Continue to provide the opportunity for outreach workers to use clinical judgment in making decisions relating to going on outreaches in pairs, going alone, requesting law enforcement to accompany them, or not go at all
- Collaborate with law enforcement to develop a statewide standardized protocol that includes law enforcement responding to DMHPs request for assistance in conducting investigations in the community. Currently there are some police departments in the state that do not respond to requests for coordinated outreaches or will not go to someone's home if they are a risk to themselves (suicidal), only if they are a risk to someone else.
- Consider making all assaults on mental health crisis workers felonies as is the case with assaults on police officers

Appendix 1

WSH Safety Summit Agenda

September 18, 2006
8:30 am to 4:30 pm

8:45	Opening Remarks (Safety Study Information)	David Kludt & Ian Harrel
9:15	State House Representative	Rep. Tami Green
9:45	Facility Design (Ergonomic Specialist)	Leslie Gamble
10:45	Break	
10:55	Police Department Safety in Outreaches	Joe Fountain
12:00	Lunch	
1:00	Access to Information	Darleen Vernon
2:00	Break	
2:10	Training	Drew McDaniel
2:45	Clinical Judgment	Jo Moore
3:15	Collaboration	Tim Davis
3:45	Break	
3:55	Wrap Up Group Discussion, Survey	David Kludt & Ian Harrel
4:30	Conference Adjournment	

Appendix 2

Pasco Safety Summit Agenda

September 20, 2006
8:30 am to 4:30 pm

8:45	Opening Remarks (Safety Study Information)	David Kludt & Ian Harrel
9:15	Police Department Collaboration	Jan Dobbs
9:45	Police Department Safety in Outreaches	Keith Cummings
10:45	Break	
10:55	Facility Design (Ergonomic Specialist) video	Leslie Gamble
12:00	Lunch	
1:00	Access to Information	Darleen Vernon
2:00	Break	
2:10	Training	Ann Glynn
2:45	Clinical Judgment	Bea Dixon
3:15	Break	
3:25	Wrap Up Group Discussion, Survey	David Kludt & Ian Harrel
4:30	Conference Adjournment	

Appendix 3

Safety Summit
Questionnaire

Name _____ ***(You may choose to remain anonymous if desired)***

Title _____

Are you represented by a labor organization? ☐Yes ☐ No

Where do you work? ☐ Urban area ☐ Rural area
☐ In an office ☐ Providing Outreach ☐Both

How many years have you worked in the mental health field? ☐ 1-3 ☐ 3-5 ☐ 5-10 ☐10+

What is your age range? ☐ 18-25 ☐ 26-40 ☐ 41-60 ☐ 60+ Sex: ☐ Male ☐ Female

What is your education level? ☐ HS Diploma ☐ AA Degree ☐ Bachelor's Degree ☐ Graduate Degree or higher

1.	Have you ever been physically assaulted during the course of performing work?	☐ Yes	☐ No	
a.	If yes, did you experience an injury that required medical attention?	☐ Yes	☐ No	
b.	Where did the assault occur?	☐ Client's Home	☐Agency	☐Other
c.	Were you alone with the client when you were assaulted?	☐ Yes	☐ No	
d.	i. Do you think that your agency took appropriate action in responding to this incident? ii. From your perspective, what was or was not appropriate in the agency response?	☐ Yes	☐ No	
2.	How safe do you feel in doing the work that is identified as your primary duties?	☐ Very Safe	☐Somewhat safe	☐ Not safe
3.	Does your agency have policies and procedures relating to staff safety?	☐ Yes	☐ No	☐ Unsure
4.	Have you received any training at work relating to safety?	☐ Yes	☐ No	
a.	If yes, do you believe that this training addressed your safety concerns?	☐ Yes	☐ No	
b.	What additional training would be most helpful to you?			
5.	Does your agency have policies and procedures that allow for 2 employees to go on outreaches when needed?	☐ Yes	☐ No	☐ Unsure
6.	Do you believe that your personal safety would be increased by the presence of another agency staff?	☐ Yes	☐ No	
7.	Do you believe that mental health staff doing community outreach should always work in pairs?	☐ Yes	☐ No	
a.	Are you able to request a partner for outreach an when you have safety concerns?	☐ Yes	☐ No	
8.	Do you believe that mental health staff doing crisis outreach	☐ Yes	☐ No	

	should always work in pairs?			
a.	Are you able to request a partner for outreach an when you have safety concerns?	☐ Yes	☐ No	
9.	If your agency had a policy that allowed for it, would you choose to use pepper spray?	☐ Yes	☐ No	
10.	If your agency had a policy that allowed for it, would you choose to wear protective clothing (flack jacket, Kevlar)?	☐ Yes	☐ No	
11.	Do you believe that law enforcement is helpful when you contact them during the course of doing outreaches?	☐ Yes	☐ No	☐ N/A
12.	Do you believe that you have access to necessary information relating to clients in order to make decisions about safety?	☐ Yes	☐ No	☐ N/A
13.	Do you believe that the state should financially support and require community mental health providers to provide a standardized safety training curriculum or should individual agencies provide their own training curriculum?	☐Statewide standardized training	☐Individual agency training	
14.	What do you need in order to feel the most safe in doing your job?			
15.	What additional comments or ideas do you have relating to safety? *(Changes in state law, changes in DMHP protocols, additional agency policies, training requirements, etc.)*			